INJURY COMPENSATION GUIDE

for USDA supervisors

FOR A SAFE FUTURE...

Safety Now

OFFICE OF PERSONNEL • U.S. DEPARTMENT OF AGRICULTURE

Contents

A brief manual to assist supervisors and others concerned with handling and reporting work injuries. Keep this Guide and a folder of Employees' Compensation Materials handy.

INJURY COMPENSATION GUIDE

for USDA supervisors

Remember: ***All injuries should be reported immediately. Form CA–1 should be completed within 48 hours.***

To assure full protection for the injured and his family, report in writing every injury, occupational disease, or death incurred in line of duty.

Office of Personnel • U.S. Department of Agriculture • October 1963

Preface

It is important that supervisors be familiar with employees' rights and benefits under the Federal Employees' Compensation Act. The benefits provided are not fully effective when reports of the injuries or other necessary forms and documents are delayed or incompletely presented.

When an employee sustains an injury in the performance of duty or incurs a disease or disability which is caused by or directly related to his employment, he is entitled to certain benefits provided by the Federal Employees' Compensation Act, unless the injury or disability is caused by the employee's willful misconduct, intoxication or intention to bring about injury to himself or another. Benefits provided by the Act are described in this guide.

It is essential that the responsible persons know what to do when someone is injured on the job. In such cases, this booklet should be helpful. More detailed information may be obtained from your agency personnel office. It can be particularly helpful in the event of difficult or complex cases. Your agency also provides for the distribution of appropriate instructions and regulations.

This booklet is a simplified guide to frequently used procedures under the Federal Employees' Compensation Act, which provides for medical care, compensation, and other benefits when employees of the Department are injured in the performance of their duties. It is designed to help supervisors and others in processing notices of injury and claims for compensation.

Carl B. Barnes
Director of Personnel

Henry F. Shepherd
Department Safety Officer

When an Employee Is Injured at Work

- *Help him get care and compensation*

  Take steps to prevent similar accidents

When an Employee Is Injured at Work

How You Can Help The Injured Employee

You are a supervisor. You have certain work goals to achieve, and you expect quality work. You treat your employees fairly and morale is high. Then, suddenly one day, Tom Gay is hurt. He trips over a telephone wire and sprains his ankle. What do you, as a supervisor, do for him?

Tom limps about and says, "It's O.K. I think I'm all right." But is he? After a moment of concern the other employees resume work. Tom sits down and rubs his ankle. As his supervisor, the problem is now yours. There are certain things you must do.

1. See that he gets necessary medical treatment right away.
2. Tell him about possible compensation benefits he may have.
3. Follow up with the paperwork needed to protect his benefits.
4. Take corrective action to prevent similar accidents.

What You Should Know

You should have a general knowledge of the benefits provided by the Compensation Act and the procedures to be followed to obtain them.

What You Should Do

Tom is entitled to immediate first aid and full medical care, including hospitalization, if needed, without cost to him. However, you should have him use Government medical facilities and designated private physicians when they are available. You can get this information from your administrative officer. He should have a list of doctors and hospitals approved by the Bureau of Employees' Compensation.

Of course, if Tom's case is an emergency requiring immediate attention, any duly qualified physician may render him necessary emergency treatment.

Similarly, where no Government medical facility or designated physician is available in the town or community, medical treatment or examination may be secured from any qualified physician.[1]

[1] The Compensation Act defines the term "physician" to include surgeons and osteopathic practitioners within the scope of their practice as defined by State Law. The Act does not provide for treatment by chiropractors, chiropodists, Christian Science practitioners, etc.

Authorization for prolonged medical treatment by non-designated physicians should generally be obtained from the Bureau of Employees' Compensation. (The Bureau of Employees' Compensation will be referred to in the following pages as BEC.)

Authorizing Medical Care

Request for medical treatment or examination must be made in writing by the official superior. In emergency cases such requests may be made verbally and confirmed in writing later. While such requests may be made by letter the following forms are provided and should be used as indicated.

Requesting Treatment or Examination From a Government Medical Facility or a Physician:

1. If you know Tom hurt himself on the job, use *Form CA–16, Request for Treatment.*
2. If the cause of injury is in doubt or if the relationship between the disability and the job is not clearly established, use *Form CA–17, Request for Treatment Where Cause of Injury is in Doubt.* Generally, Form CA–17 should be used in cases involving hernia, backache, or disability of uncertain origins.

Requesting Treatment or Examination From a Nondesignated Facility or Physician:

When there is no designated facility or hospital available in the town or community use *Form AD–365, Authorization for Nondesignated Physician or Hospital to Treat Injury.* Complete part one or two as applicable depending upon whether there is doubt as to cause of injury.

Treatment for Recurrence of Disability:

If an injured employee complains of a recurrence of disability or if he requests a renewal of medical treatment for the results of an injury previously accepted by BEC, the official superior may authorize additional treatment or examination by issuing the appropriate Form as indicated above, provided (*a*) he believes the disability is due to the injury and (*b*) 6 months shall not have elapsed since the last treatment or action on the case by BEC. If more than 6 months have elapsed or if there is any doubt that the disability is due to the previous injury, the official superior shall request authorization from BEC by submitting a memorandum

through usual channels explaining all known facts. If the employee is in urgent need of medical attention such request should be made by wire.

Employee's Notice of Injury or Occupational Disease

Impress on Tom that he needs to make a record of his injury no matter how slight it appears. Have him fill out a Form CA–1, in his own words, within 48 hours. His failure to do this could mean denial of his claim.

If Tom's injury is very minor, if no medical treatment other than local first aid is required, and if he loses no time from work, send the completed CA–1 to your personnel office where it will be kept as a permanent record in the employee's official personnel folder.

The new CA–1 (April 1962) requires witness' and immediate superior's statements on the reverse side of the form.

Older editions of CA–1 may still be used in which case the signed and dated witness' statements should be attached to the CA–1.

Supervisor's Report of Accident

After you have arranged for first aid or other medical care for Tom, or determined that none is necessary, you, as supervisor, should investigate to determine exactly what happened to cause the accident and what can be done to avoid a similar occurrence. Record your findings on Form AD–278. This is a Department requirement and, so far as this Department is concerned, no injury report will be considered complete without this signed statement of the supervisor's findings. Definite statements should be made in reply to *each question.* If not applicable answer N/A or None. Particular care should be taken in answering all items relating to corrective action taken and recommendations for preventing similar occurrences.

Official Superior's Report of Injury

If it appears that Tom's injury will be serious enough to require medical attention or if there is a loss of time from work beyond the day the injury occurred, the official superior must complete CA–2. In filling out this form, pay particular attention to items 21 through 26. Do not leave them blank. Your personnel office will advise you as to the distribution and number of copies needed. Send the original through your administrative channels to the appropriate office of BEC. There is a list of BEC offices in the back of this guide.

Briefly, make out a CA–2 if—

1. There is to be any bill to BEC.
2. Tom will be away from his work beyond the day of injury.
3. Tom's injury might result in future disability.
4. Any permanent disability results (including total or partial loss, or loss of use, of a member or function of the body).
5. There is any serious disfigurement of his face, head, or neck.
6. There is a recurrence of disability resulting from the original injury. In this event, write the word "Recurrence," in the top margin of the form.

File That Injury Claim Promptly

If Tom's disability is not likely to exceed 3 days, you can hold up the CA–1 and CA–2 forms until he has returned to work. Then fill in the date and hour that Tom returned to work and send both forms to BEC through your established channels. Of course, if you know that Tom will be disabled more than 3 days, send the forms immediately. In any event, the CA–1 and CA–2 should be mailed to BEC within 10 days. GIVE TOM A FAIR CHANCE TO ESTABLISH HIS CLAIM.

Action in Difficult or More Serious Injury Cases

The forms and reports prescribed above are basic reports only and will cover only the relatively minor injuries. In doubtful or more serious cases additional forms may be required in varying combinations depending on the nature and extent of injury. Some of these are:

CA–3 Report of Termination of Total or Partial Disability
CA–4 Claim for Compensation on Account of Injury
CA–4a Claim for Augmented Compensation
CA–8 Claim for Continuance of Compensation (submitted after each 15 or 30 days)
CA–32 Report on Hernia
CA–5 Claim for Compensation on Account of Death.

Should Tom's injury prove to be a serious one your administrative officer or your personnel office will furnish any of the above forms that may be requested and instructions regarding their use.

A Summary of Your Basic Responsibilities

Now let us see what you have accomplished. By following these first few steps you have helped the Department obey the Federal law. You have helped a fellow employee obtain any medical care and compensation to which he is entitled. You have filled out the principal forms and, in effect, issued Tom an insurance policy. Just as important, you have noted what happened to Tom. You have taken the action necessary to prevent a recurrence, or, if that is beyond your authority, you have recommended remedial measures to your superior. Thus, you have helped strengthen the safety program designed to STOP WORK INJURIES. You are working toward a solution to reduce making out all these forms.

Be sure to do this:

- See that each employee under your supervision is informed of his rights under the Compensation Act and that he knows how to properly report an injury.
- Display the poster "WHAT TO DO IN CASE OF INJURY," Form CA–10, in a conspicuous place.
- Furnish each new employee with the pamphlet "When Injured At Work," Form CA–11. This may be included in the orientation packet furnished to new employees in your agency. If so, discuss it with him.

  Note: Forms CA–10 and CA–11 may be secured from BEC without cost. Orders should be sent through the usual administrative channels. Also, CA–11 is now reprinted in Appendix II of the USDA Employee Handbook.

All Rights and Benefits Described Are Subject to Change Through "Due Process"

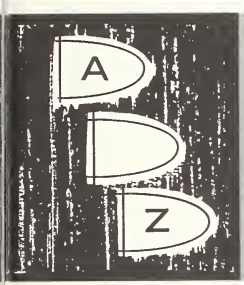
Avoid the

Accident

That Causes

The Injury

In Brief the Law Provides





- *Basic medical rights*
  Basic financial benefits
  Rehabilitation

In Brief the Law Provides

Work Injuries Covered

All injuries at work and diseases resulting from employment are covered except:

- Injuries or death caused by willful misconduct of the employee
- Injuries or death of an employee caused by his intention to bring about the injury or death of himself or of others
- Injuries or death resulting from intoxication of the injured employee.

Basic Medical Rights

The injured employee is entitled to first aid and full medical and hospital care for the injury, including transportation necessary to receive them without cost to him. However, he must use the Government medical facilities and designated physicians when they are available. When such are not available in the city or community or in case of emergency, any duly qualified physician may render treatment (see Definition of Qualified Physician footnote 1 page 2)

An employee's right to receive medical care for a compensable injury or disease does not cease on his retirement under the Civil Service Retirement Act.

Basic Financial Benefits

If the injured employee loses more than 3 days without pay, he is entitled to compensation for loss of wages.

The least he will receive per month is $180 (provided his pay is that much), the most, $525. Within these limits the amount will be based on the employee's monthly pay before deductions. If he has no dependents, he will receive two-thirds of his monthly pay; if he has dependents, he will receive three-fourths. The monthly pay on which compensation is based may be whichever of the following is most favorable to the injured employee:

(1) The monthly pay at the time of the injury,
(2) The monthly pay at the time compensable disability begins, or
(3) The monthly pay at the time compensable disability recurs if such recurrence begins more than 6 months after the injured employee resumes regular full-time employment with the United States.

Waiting Period

A 3-day waiting period in nonpay status is required before an injured employee is entitled to compensation for loss of wages.

If absence from work due to the injury continues for longer than 21 calendar days without pay, or if there is any permanent disability, then compensation (is payable) for the total period of disability, including the 3-day waiting period.

Sick and Annual Leave

If an injured employee has sick or annual leave to his credit at the time disability begins, he has the right to elect (1) to use such leave to cover all or part of his absence, or (2) to go on leave without pay and apply for disability compensation. If he elects to use leave the 3-day "Waiting Period" will not begin until leave stops.

In making this determination the injured employee should consider such factors as:

(1) The amount of leave to his credit
(2) The likelihood of needing leave for other purposes
(3) The applicability of the 3-day waiting period
(4) The net financial gain or loss (compensation payments are not subject to State or Federal income taxes or to retirement deductions).

Loss of Earning Capacity

If an employee returns to work but, due to his injury, is unable to perform his regular duties and takes a lower paying job, he is then eligible for compensation based on his loss in earning capacity.

The rate of injury compensation is 66⅔ percent of the loss of earning capacity if he has no dependents; 75 percent of the loss if he has a legal dependent. The rate can never exceed $525 per month.

Permanent Partial Disability

The act provides a schedule of payments for loss, or loss of use, of a leg or arm or other part of the body. These payments are in addition to payments for periods of temporary disability. Payments continue for a certain number of weeks, depending upon the part of the body that is affected. The following table shows the number of weeks of compensation payable in the event of

100-percent functional loss or dismemberment of certain body members. For a partial loss, the award will be for a proportionate number of weeks. These payments are at the full weekly compensation rate and are in addition to any payments for periods of temporary disability. They can be paid while the employee is being paid his regular salary after his return to duty or while drawing retirement pay under the Civil Service Retirement Act.

Where loss of earning capacity persists after schedule payments are completed for 100-percent loss or loss of use of major anatomical members, compensation may be continued for loss of earning capacity. Major members include arm, leg, hand, foot, and eye. Total loss of hearing of both ears is also treated in this manner.

Scheduled Disabilities

For loss of, or loss of use of	*Weeks of Payment*
Arm	312
Leg	288
Hand	244
Foot	205
Eye	160
Thumb	75
First finger	46
Great toe	38
Second finger	30
Third finger	25
Toe (other than great toe)	16
Fourth finger	15
Complete loss of hearing (one ear)	52
Complete loss of hearing (both ears)	200

Disfigurement.—Proper and equitable compensation not to exceed $3,500 as determined by the Bureau in addition to any other compensation payable under this schedule, is authorized for serious disfigurement of the face, head, or neck, if it is of a character likely to handicap a person in securing or maintaining employment.

Eye or hearing.—The degree of loss of vision or hearing under this schedule is determined without regard to correction.

The schedule also has provision for awards for loss of sight and binocular vision, for multiple amputations and partial loss, or partial loss of use, of a body part or function. For the complete schedule see, "Regulations Governing Administration of the Federal Employees' Compensation Act of September 7, 1916, as Amended."

Payments under this schedule are not affected by return to work without reduction in pay, or if the injury occurred on or after September 13, 1957, by retirement under the Civil Service Retirement Act.

Permanent Total Disability

Some types of injuries are considered *prima facie* to constitute permanent total disability, such as loss, or loss of use, of both hands, both arms, both feet, both legs, or both eyes. There are other situations in which BEC may determine from the evidence that an employee is permanently and totally disabled as a result of a work injury.

In such case, the employee will receive benefits for the remainder of his life. The benefits will be proportionate to the loss of wage-earning capacity.

A disabled employee who requires the constant services of an attendant, is entitled, over and above his injury compensation benefits, to an allowance not to exceed $125 per month.

Rehabilitation

The Act authorized vocational rehabilitation of an employee who is prevented from returning to his usual work because of his injury and, when necessary, payment of additional compensation up to $100 per month for maintenance while he is undergoing an approved course of training.

Death

If an employee dies as a result of a work injury or disease, even if he leaves no legal dependent, necessary burial expenses up to $800 may be paid.

If death occurs away from his headquarters, the Government will pay reasonable and necessary expenses for embalming and transporting his remains from the place of death to his home. In addition to the necessary burial expenses, the cost of returning the remains, including the cost of a hermetically sealed casket, will be paid.

If there are no unmarried children under 18, the decedent's wife will receive regularly 45 percent of his salary, figured on a monthly basis, until her death or marriage.

If there are dependent children, her payment will be figured at 40 percent plus 15 percent for each child. The Act also makes provisions for any grandparents, parents, brothers, sisters, grandchildren, or others who were financially dependent upon the decedent at the time of his death. The total monthly payment may never exceed 75 percent of the decedent's salary or $525 per month, whichever is less.

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Transportation of Injured Employee

Authorization to travel away from the immediate area for the purpose of securing medical or hospital treatment, appliances, or supplies, or for medical examination must be obtained from BEC. This, of course, does not preclude immediate movement of an injured employee to a hospital or doctor's office in an emergency.

When the means of transportation is not furnished by the Government, claim for reimbursement for such cost and necessary incidental expenses are payable by BEC and may be claimed by submitting Standard Form 1012, Travel Voucher.

Proper claims for reimbursement of travel by automobile will be paid at the rate per mile fixed by law or by Executive, administrative, or other order for employees of the United States authorized to travel at Government expense, as determined by BEC.

Claims of this nature submitted by a party other than the injured employee (a coworker who drove him to the hospital, for instance) must contain a statement signed by the injured employee that the services were rendered and that he has not paid any portion of the bill.

Note: An injured employee away from his headquarters does not have authority to sign an authorization for treatment, Form CA–16 or CA–17 (or the equivalent) as official superior. In an emergency situation the nearest available qualified physican or hospital may be utilized with the understanding that the employee will contact his official superior at the earliest practicable date for authorization. In nonemergency situations it is advisable to secure authorization from the official superior, if practicable, before securing medical services.

Note: An employee who is to be assigned to a foreign post should be briefed on compensation regulations before departure and provided with necessary injury reporting forms.

Injuries Caused by a Third Party

If an injury or death for which compensation is payable under the Act is caused under circumstances creating a legal liability on some person other than the United States (third party) to pay damages therefore, the injured employee or his beneficiary may be required to (1) prosecute an action for damages against such person, (2) settle or compromise a suit for damages, or (3) assign his right of action to the United States. The refusal to take such action may deprive him of his rights to any benefits provided by the Compensation Act.

This provision of the law is intended to relieve the Government (taxpayer) from having to pay injury or death costs which rightfully should be paid by the person responsible or legally liable. For example, when an employee sustains an injury in an auto accident where the other fellow was at fault, he (the other fellow) or his insurer should be required to pay the costs. This provision will not reduce in any way the amount or type of benefits to which the employee may be entitled. It only affects the source of such payments.

Procedures To Be Followed in Third Party Cases

The official superior shall conduct a sufficient investigation in cases involving a third party to determine the probable liability. This can be done in connection with the regular accident investigation. When third party liability is reasonably apparent a special written report setting forth the facts with supporting data shall be furnished by the official superior with his report on CA–2. This report shall be sent to the Subrogation Branch, Office of Solicitor, U.S. Department of Labor, by the officer normally dealing with BEC on injury cases unless such documentation has already been submitted to BEC with the regular injury reports.

When the circumstances clearly indicate the advisability of proceeding against the third party, the Solicitor will notify the employee or his dependent and will furnish appropriate instructions. It is the usual policy of the Solicitor in such cases to refer the employee to an attorney located in the jurisdiction where the accident occurred and who has been designated or approved by the Solicitor because of experience in handling such cases. However, it is permissible for the claimant to select his own attorney provided he secures the approval of the Solicitor for such selection.

In some cases the Solicitor will furnish a prescribed form and accept a signed statement from the employee authorizing the Subrogation Branch to act for him in effecting a recovery from the third party.

If the third party or his insurer approaches the claimant and offers to make a settlement in satis-

faction of the liability, such offer should not be accepted without the approval of the Solicitor. The acceptance of such a settlement, particularly if it is less than the computed value of the compensation benefits provided by the Act, may jeopardize the beneficiaries rights to any future compensation payments to which he would otherwise be entitled.

Related Matters

Retirement and Group Life Insurance

Insofar as Government Employees' Group Life Insurance and retirement benefits are concerned, an employee receiving monthly BEC compensation is, in effect, on leave without pay. No retirement fund or insurance deductions are made from his compensation check. His insurance remains in effect. At the end of 12 months on BEC compensation, he may, if he desires, convert his insurance to an individual policy or have it continued without cost to him.

If an injured employee is adjudged totally disabled and if he has completed at least 5 years of civilian service, he may choose whichever of the following is to his advantage:

(1) An annuity under the Civil Service Retirement Act, or

(2) Compensation under the Federal Employees' Compensation Act. His personnel office will provide him with information on both.

Health Benefits

An employee receiving monthly disability compensation, who is enrolled in a health benefits plan, may be eligible to continue his health benefits enrollment (and that of his family members) provided his injury occurred after the Health Benefits Act became effective and he has been enrolled for health benefits since his first opportunity to enroll or for 5 years preceding the start of his BEC compensation.

For the information of BEC, the employing agency is required to determine the eligibility of an employee with respect to enrollment in a health benefits plan and report its findings by certain notations on Forms CA–3 and CA–4. The procedure is as follows:

If the injured employee is not eligible, note, "Not eligible to continue health benefits," on CA–4, under "Remarks," which is item 4 of the Certificate of Official Superior of Injured Employee.

If the employee is eligible, enter in the same place, the statement, "Enrollment Code (give number). Health Benefits deductions made through (give beginning and ending dates of payroll period in which leave-without-pay began)."

When an employee who has been receiving monthly BEC compensation returns to work, his employing agency should note under the "Remarks," item 15 of Form CA–3, the beginning and ending dates of the pay period in which he returns to duty.

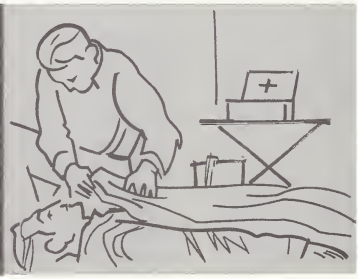
No notation on health benefits is required if BEC compensation continues for no more than 28 days and if the injury is reported after the employee's return to duty.

If there are changes in enrollment while employees are receiving compensation, BEC should be notified of the changes and the effective dates. If an employee's services are terminated because of a reduction in force or other reason while he is receiving compensation, arrangements should be made to transfer his health-benefits enrollment to BEC.

> Note: The following is quoted from the February 9, 1962, issue of the Federal Employees' Health Benefits Act News Letter (10th Regional Office, U.S. Civil Service Commission):
>
> "We have had reports of confusion that has arisen over the payment of on-the-job injuries. Some injured employees have been treated by their own physicians, expecting coverage under the Health Benefits Program. This action has resulted in a financial loss to the employee since injuries of this kind are not covered by the Health Benefits Program and improper reporting has excluded them from coverage by the Bureau of Employees' Compensation. Expenses incurred as a result of occupational disease or injury for which any benefits are payable under workmen's compensation or similar law are *not* covered by the Federal Employees' Health Benefits."

All rights and benefits described are subject to change through "Due Process."

Some Typical Situations



- *What you need to do in some typical injury and disability cases.*

Some Typical Situations

It would be impossible to cover every situation in a brief manual such as this. We have, therefore, chosen the situations that we believe will be of most value to you in your day-to-day experience. When an unusual case arises, your administrative officer (or personnel office) should be contacted for more detailed regulations. If necessary, he will seek advice from BEC.

All BEC or CA forms specified shall be forwarded thru usual agency channels for disposition as indicated in the chart shown on pages 38–41 or as otherwise directed.

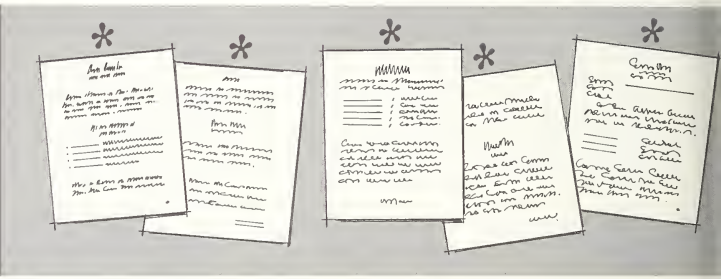
The Department of Agriculture requires that Form AD–278, "Supervisor's Report of Accident," be filled out and signed by the supervisor in every instance in which a CA–1 is needed. In the following examples when an employee must fill out a CA–1, his supervisor must complete an AD–278.

IN CASE OF	DO THIS
1. **Minor injury.** No medical treatment required—no lost time.	Have employee complete CA–1 (or other written notification) within 48 hours. His failure to do this may mean denial of his claim if injury leads to serious trouble later.
2. **Disability lasting not more than 3 days.** Injury requires treatment which is available at U.S. Public Health Service (USPHS) or other designated facility. Time lost is not more than 3 days.	Prepare CA–16, or CA–17 for initial treatment. Send employee, with original CA–16 or –17, to the nearest designated facility. The facility will forward this form with the bill direct to BEC. Have employee prepare CA–1 within 48 hours. Prepare CA–2.
3. **Disability covered by leave with pay.** Injury is fairly serious. An extended period of absence from duty will probably be required. Employee has substantial sick leave to his credit. He elects to use it, and returns to duty before sick leave is exhausted.	Prepare CA–16 or CA–17 for initial treatment. Have employee prepare CA–1, or have it prepared for him, within 48 hours. Prepare CA–2 and forward copies of all forms prepared so far through proper channels to BEC. Prepare CA–3 upon his return to duty.
4. **Disability involving compensation.** Employee doesn't have enough sick leave to cover period of his disability; or he elects to claim compensation benefits rather than use his leave.	Prepare CA–16 or –17, CA–1 and CA–2, as in Case 3. Be sure the employee understands that there is a 3-day waiting period before compensation coverage begins. Tell him approximately how much compensation he will receive. Help employee prepare CA–4; also CA–4A if he has dependents. Determine if he is eligible for continuation of health benefits enrollment and make appropriate notation on CA–4 (see Health Benefits). Prepare and forward these forms 18 days after pay stops, or upon return to duty, whichever is earlier. It is important that the information be current as of the date the forms are signed and forwarded. If disability continues beyond the date CA–4 is filed, prepare and forward CA–8 every 15 days for continuing compensation. Prepare CA–3 when he returns to duty. Make appropriate notation on CA–3 to cover health-benefits enrollment.
5. **Injury requiring emergency medical treatment.** Employee's condition shows that he may be in danger and every minute counts.	Secure prompt treatment. This is the most important thing. Call an ambulance if necessary. If practicable, rush the employee to a designated facility. Prepare and forward CA–16 or CA–17 to the facility within 48 hours.

IN CASE OF	DO THIS
	Or, call any neighborhood doctor if the USPHS or other designated facility is too far away. Then prepare a brief letter or form AD–365 as in Case 6. CA–1 and CA–2 are required in every case; other Forms may be necessary depending on the circumstances.
6. **No available designated physician or facility.** Injury requires treatment but there is no USPHS or other designated medical facility or physician near the location.	Request treatment in writing from any qualified physician. Use Form AD–365 or a brief letter. If a letter is used it should request treatment of the injured employee and should contain billing instructions. Send employee, with original of request, to the hospital or physician. Have employee prepare CA–1 within 48 hours. Prepare CA–2. Forward immediately all forms prepared so far; include carbon copy of the letter requesting treatment. Advise personnel office if prolonged treatment is likely. If it is, authorization for same must be obtained from BEC. Let your action from this point be guided by the circumstances in the case and the instructions you receive from your personnel office and or BEC.
7. **Recurring disability.** Employee returned to work after injury, following treatment and discharge. Later he complains of a recurrence of the disability.	If less than 6 months have elapsed since discharge, and if it is reasonable to assume that there is a connection between the prior injury and present complaint, prepare CA–16, mark it "Recurrence" and send employee, with the original of this form, to designated facility for treatment. Fill out CA–2, marking it "Recurrence." Show clearly when employee stopped work again and what part of the new absence is covered by leave. Prepare CA–3 when employee returns to duty unless date of return to duty was shown on CA–2. Make appropriate health-benefits notation on CA–3. If it has been more than 6 months since the apparent recovery, or if there is good reason to doubt that present disability is due to the injury, request instructions from your personnel officer by memorandum, stating all pertinent facts of the case.
8. **Doubtfully compensable disability.** Injury requires treatment, but there is some doubt as to whether circumstances of the injury would entitle employee to benefits under the Compensation Act. Prolonged treatment or extended disability is likely.	Prepare CA–17. Send employee, with original CA–17, to nearest designated facility. The facility will forward it, with its bill to BEC. Have employee prepare CA–1 within 48 hours. Prepare CA–2. Forward CA–1 and CA–2. Be guided, from this point, by advice received from BEC through your personnel officer. If employee returns to duty before advice is received, prepare and forward CA–3.
9. **Certain permanent disabilities.** Employee's injury resulted in loss, or loss of use, of some part of his body, or in disfigurement of face, head, or neck.	Refer to the Schedule of Payments of the Regulations Governing Administration of the Federal Employees' Compensation Act. Payments for functional loss or dismemberment of certain body parts are in addition to any payments for periods of temporary disability. These scheduled payments may be made even though the employee has returned to work. Use CA–4 to make claim for this type of compensation; other forms will depend on circumstances in the case.

IN CASE OF	DO THIS
10. **Hernia.** Employee is suffering from hernia, which he believes is the result of heavy lifting done on the job. May require operation.	Prepare CA–17. (CA–16 is never used in hernia cases.) Or part 2 of Form AD–365 if appropriate. Have employee prepare CA–1 within 48 hours. Have employee complete face of CA–32. Send employee, with originals of the authorization and CA–32, to a physician for examination and emergency treatment if required. Instruct the employee to (1) bring back the CA–32 after the reverse side has been filled out by the physician, or (2) request the physician to mail the completed form to the supervisor. Prepare CA–2. From this point, other forms will depend on circumstances on the case.
11. **Injury involving a third party.** A laborer on duty at a Government warehouse is injured by a truck belonging to a private company.	Prepare authorization for treatment and CA–1 and –2. Prepare detailed statement telling all facts connected with the accident as far as you have been able to determine them, and attach to CA–2 for forwarding to BEC. Advise employee of the regulations in third party cases; caution employee not to sign any papers which would release owners of the truck from possible legal liability. BEC will investigate the possibility of legal action if the injury results in any charge against the compensation fund. Other forms, as necessary, according to future developments.
12. **Death.** Employee is killed outright or dies as a result of an injury in line of duty.	Notify personnel officer immediately by telephone or telegraph giving brief account of what happened. The officer normally dealing with BEC shall *notify BEC of the death immediately.* If CA–2 hasn't been submitted, prepare now. Prepare CA–3. If death was immediate, fill in lower portion only. If death followed earlier injury, show in upper portion exact period of absence prior to death and whether covered by leave. If beneficiary is eligible for continuance of health benefits coverage, note Code number and beginning and ending dates of last pay period for which decedent was paid. A certified copy of the death certificate should be submitted as soon as possible—and the autopsy report, if there is one. Furnish information to beneficiary regarding benefits of Compensation Act. Help in preparing compensation claim on CA–5. Forward all forms to BEC.
13. **Occupational Disease.** Employee develops symptoms suggestive of occupational disease which he attributes to his work environ or exposure; or occupational disease is suspected for other reasons. (Some possible diseases proximately caused by employment might be silicosis, tuberculosis brought on by silicosis, the effects of chemical poisoning, etc.)	Prepare CA–17 and send employee, with original, to the nearest designated physician. Have employee prepare CA–1. Advise him that detailed information is usually necessary to establish a connection between a disease and occupational exposure. Tell him to include a complete description of his working conditions, length of exposure, hours worked, suspected causative agency, substance or substances, date of first recognizable symptoms, and any other facts bearing on his claim. Make a thorough investigation of the circumstances of the case, then prepare CA–2, basing it on your investigation. Cover all pertinent facts. Send CA–1, CA–2, and a copy of CA–17, through channels, to BEC. Be guided from this point by advice from BEC. If employee loses time from work but returns before advice is received, prepare CA–3 and forward it to BEC.

A Typical Injury Case



- *The following sample forms may assist you in preparing cases*

U.S. DEPARTMENT OF LABOR
Bureau of Employees' Compensation

EMPLOYEE'S NOTICE OF INJURY OR OCCUPATIONAL DISEASE
(Under the Federal Employees' Compensation Act)

INSTRUCTIONS

This form should be completed by the injured employee or someone on his behalf whenever an injury is sustained in the performance of duty and given to his immediate superior within 48 hours. It should be placed in the employee's official personnel file unless the injury causes disability for work beyond the day when it occurred; is likely to result in prolonged treatment or permanent disability; or in a charge for medical or related expenses when it should be forwarded to this Bureau with Form CA-2, Official Superior's Report of Injury. This form is also completed whenever an employee believes he suffers from a disease related to his employment. (See Sections 1.2, 1.3, 2.2 and 2.3 of the Bureau's Regulations.)

The immediate superior should also complete the reverse side of this form.

1. NAME OF INJURED EMPLOYEE *(Last, first, middle)*
Squeeks, Dan P.

2. DATE OF THIS NOTICE *(Mo., day, yr.)*
August 14, 1962

3. PLACE OF EMPLOYMENT *(Name and location of office or establishment)*
Olson Canyon Fire U. S. Department of Agriculture
Lincoln National Forest, Forest Service Code No._____

4. DATE OF INJURY *(Mo., day, yr.)*
August 14, 1962

5. OCCUPATION
Firefighter II

6. HOUR OF INJURY *(a.m. or p.m.)*
8:30 a.m.

7. PLACE OR LOCATION WHERE INJURY OCCURRED
Olson Canyon, Lincoln National Forest

8. CAUSE OF INJURY *(Describe how and why injury occurred)*
Fire had just gotten into young growth; it started crowning and travelling fast. My foreman, Everett L. Hadley, upon sensing the danger, hollered for me to clear out for safety. I made a dash for safety and in doing so accidentally ran into a protruding limb from a downed snag.

9. NATURE OF INJURY *(Name part of body affected—fractured left leg, bruised right thumb, etc.)*
Bruished right arm; skinned face; slight burn of skin on face.

10. NAMES OF WITNESSES TO INJURY
Everett L. Handley and Charles M. Miller, Mayhill, New Mexico

11. IF THIS NOTICE WAS NOT GIVEN WITHIN 48 HOURS AFTER THE INJURY, EXPLAIN REASON FOR DELAY. IF EARLIER NOTICE WAS GIVEN, VERBAL OR WRITTEN, STATE WHEN AND TO WHOM.
Given within 48 hours

I certify that the injury described above was sustained in the performance of my duties as an employee of the U.S. Government and that it was not caused by my willful misconduct, intention to bring about the injury or death of myself, or another, nor by my intoxication. I hereby make claim for compensation and medical treatment to which I may be entitled by reason of this injury.

12. SIGNATURE
/s/ Dan P. Squeeks

13. HOME ADDRESS OF INJURED EMPLOYEE
314 Florida Avenue
Alamogordo, New Mexico

Form CA-1, Apr. 1962. Edition of Oct. 1952 may be used. Labor 1400

CA-1 Employee's Notice of Injury or Occupational Disease (front of form)

693-506 O - 63 - 3

STATEMENTS OF THE IMMEDIATE SUPERIOR AND WITNESSES TO THE INJURY

The immediate superior should submit a statement and secure statements of witnesses where possible. The statements should tell just what each personally knows about the injury, and how and when such knowledge was obtained.

14. DATE CA-1 RECEIVED BY AGENCY *(Mo., day, yr.)*	15. CA-1 RECEIVED BY WHOM
August 14, 1962	Everett L. Hadley

16. STATEMENT OF IMMEDIATE SUPERIOR

This is to certify that I was foreman of a gang of 11 men on the south fork of the Olson Canyon Fire; with the crew was attempting to hold the fire from getting into young growth where extreme danger of crowning would exist. Eventually the fire did get into this young growth and when danger to crew was perceived, issued the order to run for safety. Dan P. Squeeks was perhaps closer to the fire than any other member of the crew. He so quickly perceived the danger that he jumped blindly into a snag. I assisted him to a point of safety.

17. SIGNATURE OF IMMEDIATE SUPERIOR	18. DATE *(Mo., day, yr.)*
/s/ Everett L. Hadley, FF Crew Boss	August 14, 1962

19. STATEMENT OF WITNESS

Attached

20. SIGNATURE OF WITNESS	21. DATE *(Mo., day, yr.)*

22. STATEMENT OF WITNESS

23. SIGNATURE OF WITNESS	24. DATE *(Mo., day, yr.)*

U.S. GOVERNMENT PRINTING OFFICE : 1962 OF—637331

CA-1 Employee's Notice of Injury or Occupational Disease (back of form)

S A M P L E

Witness statements may be made on reverse of Form CA-1, or by combination of the two as necessary.

STATEMENT OF CHARLES M. MILLER, CONCERNING INJURY SUSTAINED BY DAN P. SQUEEKS, FIREFIGHTER II, August 14, 1962

This is to certify that I was working under Crew Boss Hadley and about eleven men on the south fork of the Olson Canyon Fire, August 14, 1962. The fire endangered the crew, and Crew Boss Hadley issued orders to run for safety. We all took off quickly and Dan P. Squeeks seemed to run into a limb of a tree which knocked him on the ground. Someone helped him up and when we arrived at a point of safety I noticed his face was burned or blushed and badly scratched on the right side. Also, he was limping and claimed that he hurt his right leg in his getaway from the fire.

/s/ Charles M. Miller
FF Strawboss

Sample Statement of Witness

OFFICIAL SUPERIOR'S REPORT OF INJURY

SAMPLE

[To be submitted to U. S. DEPARTMENT OF LABOR, BUREAU OF EMPLOYEES' COMPENSATION, Washington 25, D. C., as soon as practicable after any injury to a civil employee of the United States sustained while in the performance of duty which causes any disability for work beyond the day or shift on which the injury occurred or results in any charge against the Bureau for medical expense. This form should be accompanied by C. A. 1.]

Place of employment

1. Department Agriculture (War, Navy, etc.) 2. Bureau or office Forest Service (Engineer, Navigation, etc.)
3. Place of employment Olson Canyon Fire (Arsenal, navy yard, etc.), Lincoln National Forest (City), Alamogordo (State), N.M.
4. Reporting office Olson Fire Camp, Lincoln National Forest, Alamogordo, N. M. (Location of reporting office or division headquarters)
5. Name of superintendent or foreman in charge when injury occurred A.E. Hutchinson, Fire Boss

The injured employee

6. Name of injured employee Dan P. Squeeks (Give first name in full) 7. Age 32 8. Sex M 9. Citizenship U.S.
10. Home address 314 Florida Avenue (Street and number), Alamogordo (City or town), New Mexico (State)
11. Occupation and division Firefighter II (Give both, as laborer, hull division; helper, machine shop, etc.) 12. Was employee doing his regular work? yes If not, what work?
13. Total length of service with the Government as a civilian? 2 days
14. How long at present work in this establishment? 2 days
15. Dates of other injuries None
16. Rate of pay on date of injury, $ 1.65 per hour { and subsistence valued at $ .20 per hour; and quarters valued at $ ____ per ____
17. Employee begins work at various (Hour, a. m. or p. m.) m. 18. Regular day's work ends various (Hour, a. m. or p. m.) m.
19. Hours worked per day 12 20. Days paid per week 6

21. Place where injury occurred Olson Canyon Fire, Lincoln National Forest (Give exact location, as name or number of building and division, etc.)
22. Date of injury August 14, 1962; day of week Tuesday; hour of day 8:30 a.m. (a. m. or p. m.)
23. Date employee stopped work August 14, 1962; day of week Tuesday; hour of day 9:00 a.m. (a. m. or p. m.)
24. Date employee's pay stopped August 14, 1962; day of week Tuesday; hour of day 12:00 Noon (a. m. or p. m.)
25. Has employee returned to work? No (Give date and hour)
26. Will employee receive pay for any portion of above absence on account of:
    (a) Annual leave No (Give exact dates)
    (b) Sick leave No (Give exact dates)
    (c) Any other reason No (Give exact dates)

CA-2 Official Superior's Report of Injury (front of form)

27. Describe in full how injury occurred In attempt to escape the fire, Mr. Squeeks ran into a protruding limb.

28. State part of body injured and nature and extent of injury Bruised right arm; skinned face, slight burn of skin on face.

The injury

29. Did injury cause loss of any member or part of member? No If so, describe exactly

30. Was employee injured while in performance of duty? Yes If not, or in doubt, give detailed statement

31. Was injury caused by:
(a) Willful misconduct of the employee? No (b) Intention of employee to bring about injury or death of himself or another? No (c) Employee's intoxication? No
(If any answers to these questions are made in the affirmative, the reporting officer should attach an additional statement giving the reason for his conclusion)

32. Was written notice of injury given within 48 hours? Yes If not, did immediate superior have actual knowledge of injury?
(Answer to question 5, Form C. A. 1, must be complete if notice was not given within 48 hours)

33. Names and addresses of witnesses to injury Everett L. Hadley, Mayhill, New Mexico
Charles M. Miller, Mayhill, New Mexico
(If disability will continue for more than one day, have statements of witnesses made on reverse side of this form)

34. Was injury caused by a third party other than a Government employee or agency? no If so, has employee been instructed in procedure under the Bureau's regulations?
(A detailed statement should be forwarded with this report)

Medical attendance

35. Name and address of physician who first attended case Dr. John Q. Jones, Alamogordo, N. M.

36. How soon after injury? 3 hours

37. To what hospital sent? Gerald Champion Hospital Location Alamogordo, N. M.

38. Name and address of physician now attending case same as item 35

Signed this 15 day of August, 19 62

at Olson Canyon Fire Camp, Lincoln, N. F.

/s/ D. P. Stevens
(Signature of reporting officer)
Camp Officer
(Title)

C. A. 2
Revised April 15, 1953

(OVER)

19

STATEMENT OF WITNESSES

[The statement of witness should tell just what the witness saw personally, or, if he did not see the injury occur, just what he knows about it and when and by whom the information was given him.]

NOTE: Statements of witnesses should be either included on the back of Form CA-1 or obtained in narrative form on blank paper and attached to Form CA-1. Witness statements must be in sufficient copies to provide one for each Form CA-1 required.

Signed this _____ day of _____, 19_____

_____

(Signature of witness)

Signed this _____ day of _____, 19_____

_____
(Signature of witness)

STATEMENT OF GOVERNMENT MEDICAL OFFICER OR PHYSICIAN WHO FIRST EXAMINED CASE

I CERTIFY that _____ *(Name of employee)* was given first-aid treatment, or examined, on _____, 19_____, at _____ m., and _____ *(Was or was not)* disabled for work. Probable length of disability will be _____ In my opinion disability _____ *(Was or was not)* due to injury on _____, 19_____

Nature of injury as found on examination _____

NOTE: This statement need not be completed if the physician makes his report on CA-20.

Hospitalized _____ Will return for further treatment _____

Discharged _____ Other disposition _____

Remarks _____

Signed this _____ day of _____, 19_____

at _____

_____
(Signature of medical officer)

_____
(Title)

U.S. GOVERNMENT PRINTING OFFICE 1959—O-530749

Form C. A. 16

REQUEST FOR TREATMENT OF INJURY UNDER THE UNITED STATES EMPLOYEES' COMPENSATION ACT

Employees of the United States are entitled to medical, surgical, and hospital treatment under the provisions of the Compensation Act only for injuries sustained in the performance of duty.

SAMPLE

August 14 (Date), 1962

To Medical Officer in Charge, Fort Stanton, New Mexico
(Name of U. S. Hospital, U. S. Medical Officer, or Designated Physician) (Location)

THE BEARER, Dan P. Squeeks
(Name of injured employee)

is a civil employee of the United States, employed as Firefighter II
(Name of employee's occupation)

at Olson Canyon Fire, Lincoln National Forest, Alamogordo, N. M.
(Name of office or establishment where employed) (Location)

He / She was injured in the performance of duty on August 14 (Date), 1962

Nature of injury Bruised right arm, skinned face; burns on face.

Treatment is requested for the results of said injury pursuant to the provisions of Section 9 of the United States Employees' Compensation Act.

/s/ David C. Stevens
(Signature of Official Superior)

Camp Boss
(Title or official position)

Lincoln National Forest
Alamogordo, New Mexico
(Address)

When this request is addressed to a designated physician or hospital, the reason why the request for treatment is not made to a United States medical officer or a United States hospital is to be noted here

(See other side for provisions of the Compensation Act as regards treatment)

16—49518-2

CA–16 Request for Treatment of Injury
(By Government or Designated Facility or Physician)

Form C. A. 17

SAMPLE

REQUEST FOR TREATMENT OF INJURY UNDER UNITED STATES EMPLOYEES' COMPENSATION ACT WHEN CAUSE OF INJURY IS IN DOUBT

Employees of the United States are entitled to medical, surgical, and hospital treatment under the provisions of the Compensation Act only for personal injuries sustained in the performance of duty.

August 14, 1962
(Date)

To Lt. John A. Miles, Hollamon Air Force Field Contingent, Olson Canyon Fire
(Name of U. S. hospital, U. S. medical officer, or designated physician) (Location)

THE BEARER, Charles A. Cumonnau
(Name of injured employee)

is a civil employee of the United States, employed as FF Flunkie
(Name of employee's occupation)

at Olson Canyon Fire, Lincoln National Forest, Alamogordo, New Mexico
(Name of office or establishment where employed) (Location)

There are reasons to believe that he was injured in the performance of duty on August 14,
(Date)

1962. The alleged injury was due to eating spoiled meat
(Cause of injury)

The resulting disability appears to be Ptomaine Poisoning
(Nature of disability)

You are requested to examine the case and advise this office whether in your opinion the disability is due to the alleged injury. If there seems reason to believe the disability may be due to injury alleged, treatment should be rendered as provided by Section 2.5 of the Bureau's Regulations until it can be definitely ascertained whether the case is one for which treatment should be continued under said regulations and the Compensation Act.

/s/ A. E. Hutchinson
(Signature of official superior)

Fire Boss - Olson Canyon Fire
(Title or official position)

Lincoln National Forest
Alamogordo, New Mexico
(Address)

(See other side for duties of official superior when using this form)

16—5983-2

CA-17 Request for Treatment of Injury . . . When Cause of Injury Is In Doubt
(By Government or Designated Facility or Physician)

FORM AD-365 (6-63) U.S. DEPARTMENT OF AGRICULTURE

AUTHORIZATION FOR NONDESIGNATED PHYSICIAN OR HOSPITAL TO TREAT INJURY

GOVERNMENT SUPERVISORS: *Use this form to obtain treatment or examination of job-related injuries when Government medical facilities or designated physicians* **ARE NOT AVAILABLE.** *Complete Part 1* **OR** *Part 2 as applicable. Give original and one copy to physician or hospital and distribute agency copies as directed.*

FROM: (U.S.D.A. OFFICE REQUESTING TREATMENT)

DATE OF INJURY

DATE OF THIS REQUEST

NAME OF INJURED EMPLOYEE

TO: (NAME AND ADDRESS OF PHYSICIAN OR HOSPITAL)

OCCUPATION OF INJURED EMPLOYEE

PHYSICIAN OR HOSPITAL: Please treat or examine the employee named above as authorized in Part 1 *OR* Part 2, whichever has been checked. Submit your bill and medical report to the office shown in the lower left corner, in accordance with instructions appearing on the reverse of this Authorization.

☐ **PART 1** (When cause of injury *IS NOT IN DOUBT.*)

You are authorized to give emergency treatment under the provisions of the United States Employees' Compensation Act to this employee who was injured in the performance of duty. Necessary treatment may be continued unless you are advised to the contrary by this office or the Bureau of Employees' Compensation.

CAUSE AND NATURE OF INJURY:

☐ **PART 2** (When cause of injury *IS IN DOUBT.*)

You are authorized to examine this employee. Please advise this office *(address given above)* whether in your opinion the disability is due to the alleged injury described. If there is reason to believe the disability may be due to the injury alleged, treatment is requested under the provisions of the United States Employees' Compensation Act until it can be definitely ascertained whether the case is one for which treatment should be continued under that Act.

CAUSE OF ALLEGED INJURY:

NATURE OF DISABILITY:

NAME AND ADDRESS OF OFFICE TO WHICH BILL AND REPORT SHOULD BE SENT:

TITLE OF INJUREO EMPLOYEE'S OFFICIAL SUPERIOR

SIGNATURE OF OFFICIAL SUPERIOR

FORM AD-365

Form AD–365, Authorization for Nondesignated Physician or Hospital to Treat Injury, when the injury is known to be job-connected or when cause of injury is in doubt (front of form)

INSTRUCTIONS FOR CLAIMING CHARGES FOR MEDICAL AND HOSPITAL SERVICES AND FOR APPLIANCES AND SUPPLIES FURNISHED UNDER THE PROVISIONS OF THE UNITED STATES EMPLOYEES' COMPENSATION ACT

Charges for medical, hospital, surgical or other treatment or care of injured employees may be submitted on billhead stationery of the doctors, hospitals, or vendors of appliances and supplies.

1. **Submission of Bills.** Submit bills *in duplicate* itemized as indicated in Item 2 below, showing name of injured employee and nature of injury or disability treated. Submit a separate bill for each injured employee.

   (a) **Supplemental Bills.** If a doctor or hospital has paid another person, corporation, or firm for services or supplies, the amount so paid may be included in the bill of the doctor or hospital if accompanied by an itemized statement in duplicate, properly receipted in favor of the doctor or hospital.

   (b) **Frequency.** Submit bills when the injured employee is discharged from treatment, except when treatment extends for more than 30 days. In the latter event bills may be submitted at the end of each 30 days.

   (c) **Authorization and Medical Report.** Forward this Authorization and a medical report (see Item 3 below) with your first bill.

2. **Itemization Required.** Itemize bills to show the dates of treatment, nature of services or supplies, and amount charged for each.

   (a) **X Rays.** Charges for X rays should show number of views and parts of body X rayed.

   (b) **Hospitalization Charges.** Hospitalization charges should show number of days and rate per day or week. If other than ward service is used, attending physician should certify as to the necessity.

   (c) **Special Services.** Charges for services of special nurses, consultants, and for medicine, drugs, orthopedic, prosthetic and other appliances, physiotherapy, etc., should be approved by the physician in charge unless they were specifically authorized by the Bureau of Employees Compensation.

3. **Medical Reports Required.** A medical report setting forth your diagnosis, the treatment given, your recommendations (if any) and prognosis, etc., is required. Forward such report with your first bill. Forward additional reports as may be indicated.

Form AD-365, Authorization for Nondesignated Physician or Hospital to Treat Injury
Instructions (back of form)

SAMPLE

CLAIM FOR COMPENSATION ON ACCOUNT OF INJURY

[To be filed with the official superior, within 60 days after the injury causing disability for more than 3 days, for transmission to the U. S. DEPARTMENT OF LABOR, BUREAU OF EMPLOYEES' COMPENSATION]

CLAIM MUST BE FILED WITHIN ONE YEAR AFTER INJURY

NOTICE: Section 39 of the Compensation Act of September 7, 1916, provides that whoever makes, in any claim for compensation, any statement, knowing it to be false, shall be guilty of perjury and shall be punished by a fine of not more than $2,000, or by imprisonment for not more than one year, or by both such fine and imprisonment.

1. Name of injured employee Dan P. Squeeks [Give first name in full] 2. Age 32 3. Sex Male
4. Mail address 314 Florida Avenue [Street and number] Alamogordo [City or town] New Mexico [State]
5. Married, ~~single, widowed~~. 6. Citizenship ..... 7. Occupation and division Firefighter II
[Cross out two words] Lincoln Nat. Forest
8. Rate of pay when injured, $ 1.65 per hour
   (a) Were subsistence and quarters furnished by the United States? yes
   (b) If so { were they received in addition to rate of pay? yes / or / was their value deducted from pay? no } [Answer "Yes" to one]
   (c) In either case, state value: Subsistence, $ .20 per hours; quarters, $ - per -
9. Time of injury August 14 [Date], 19 62 Tuesday [Day of week] 8:30 a.m. [Hour a. m. or p. m.]
10. Disability for work began August 14 [Date], 19 62 Tuesday [Day of week] 8:30 a.m. [Hour a. m. or p. m.]
11. First able to resume usual occupation August 24 [Date], 19 62 Friday [Day of week] 8:00 a.m. [Hour a. m. or p. m.]
12. Period for which compensation is claimed. From August 14 (12 Noon) [Date] to August 24, 1962 [Date]
13. Have you received any pay from the Government during period of disability:
    On account of annual or sick leave no Dates ....., Total amount, $.....
    Specify any other reason no Dates ....., Total amount, $.....
14. Have you worked for anyone during the period of disability? no If so, give name and address of employer, dates worked, rate of pay, and total amount earned .....
15. Were you furnished subsistence or quarters (other than in hospital) during period of disability? no
    If so, give dates on which subsistence or quarters, or both, were furnished .....
16. If medical, surgical, or hospital service was furnished by private physicians or hospitals, state amount of expense incurred, $ none and submit an itemized bill for this service with an explanation of reason for not using United States medical officers or hospitals, if available.
17. If transportation and other expenses necessary to enable you to secure proper medical and hospital treatment were incurred by you, state amount of expense so incurred, $ none If reimbursement is claimed submit itemized receipted bill for such expenses.
    [Give dates, places of travel, and amount paid; also any special expense necessary because you had to travel from your regular place of residence in order to get proper medical treatment]

18. Place where injury occurred Olson Canyon Fire, Lincoln National Forest
[Give exact location, as name or number of building, and division, etc.]

19. Cause of injury Fire had just gotten into young growth; it started crowning and traveling fast. My foreman, Everett L. Hadley, upon sensing the danger, hollered for me to run for safety. I made a dash for safety and in doing so accidentaly ran into a protruding limb from a downed snag.
[State exactly how injury occurred]

20. Nature and extent of injury causing disability Burns and abrasions on face, bruised right arm

21. Have you made claim against any person for damages on account of the injury described above? no
If you have received any money in payment of damages, state amount, $ none

22. (a) Have you ever been in the military or naval service? yes If so, state approximate periods served and in what organization Air Force - 10/6/53 to 9/18/55

(b) Have you ever applied for compensation or pension on account of such service? no If so, give claim number and office where filed

(c) Are you now receiving compensation or pension, retainer, or retirement pay on account of such service? no If so, give details

23. Have you applied for, or received, annuity under Civil Service Retirement Act? no

24. Dates of other injuries, if any, on account of which you have made claims for compensation none

I HEREBY make claim for compensation on account of the injury described above, which was sustained by me while in the performance of my duty for the United States, said injury not being due to willful misconduct on my part or to my intention to bring about the injury or death of myself or another, or to my intoxication. I have been disabled on account of this injury and have not refused or failed to perform any work I was able to do during the period for which compensation is claimed and every statement set forth above in support of my claim is true to the best of my knowledge and belief.

Signed this 25th day of August, 1962, at Alamogordo, New Mexico

/s/ Dan P. Squeeks
[Signature of claimant]

/s/ Wm. A. Black
/s/ Mary Ellen Jones
Subscribed and sworn to before me this day of , 19

Completed by Notary Public or other person authorized to administer oaths for general purposes.

[Signature of official administering oath]

[Title] [In and for]

C. A. 4
Revised May 24, 1951

ATTENDING PHYSICIAN'S CERTIFICATE AND MEDICAL REPORT OF DISABILITY

(To be completed by attending physician)

I CERTIFY that _____ has been under my professional care from
[*Name of injured employee*]

_____ to _____, inclusive, for the effects of injuries sustained on

_____

In my opinion, employee has been *totally disabled* for all work from _____ to _____
and *partially disabled* for usual occupation from _____ to _____

Patient { was / may be } able to resume regular work _____

Patient { was / may be } able to resume light work _____

1. Dates of treatment visits: (*a*) Office _____
   (*b*) Home _____

2. Nature of treatment provided for e

   To be completed by attending physician

   _____

   (*a*) Operation _____ (*b*) Date performed _____

3. What further treatment is recommended? _____
   Specify special services indicated, if any, such as: Consultation, hospitalization, orthopedic appliances, etc. _____

4. State what history of injury was given by employee _____

5. Describe the symptoms or physical findings for which treatment was given _____

   (*a*) X-ray—laboratory—specialist's reports _____

6. State how your findings confirm your opinion that the disability was due to injury _____

7. Describe complicating and other concurrent diseases or disabilities present _____

8. Employee was confined (*a*) to his *home* from _____ to _____; (*b*) to *bed* from _____ to _____

9. Are permanent effects of the injury probable? _____ Describe in detail _____

10. If injury caused loss or dysfunction of a part, describe such loss in terms of function _____

NOTE.—In all cases where (*a*) the disability is protracted 30 days or more, or (*b*) where the medical relationship of the condition to an alleged injury or to occupational conditions is not clear, forward a detailed medical report describing the onset and clinical course of the condition, and discuss the medical aspects of the case which justify your opinion of the causal relationship to an injury.

I am licensed to practice medicine and surgery in the State of _____

_____
[*Signature of attending physician*]

Signed this _____ day of _____, 19____

_____ _____
[*Street and number*] [*City and State*]

CERTIFICATE OF OFFICIAL SUPERIOR OF INJURED EMPLOYEE

[Report of injury (Form C. A. 2) if not heretofore forwarded to the Bureau, should accompany this claim.]

If any circumstances have arisen which alter the conclusions stated in the official report of injury (Form C. A. 2), or if the official superior disagrees with any of the statements made in the claim for compensation, it is requested that a full explanatory statement be made under "Remarks."

1. If the injured employee is a piece worker or an irregular worker, what were his gross earnings during the month immediately preceding the injury? $_____; actual dates on which he worked _____
[*For example, if the employee was injured on the 7th of February, his gross earnings should be given for January 7 to February 6, inclusive*]
2. Has employee resumed work? _____ If so, give date and hour _____
3. Has employee been paid for any portion of the absence for which compensation is claimed? _____ If so, state inclusive dates _____
(To be completed by fire forest headquarters)
4. Remarks "Not eligible to continue Health Benefits" or if eligible show, "Enrollment code (give number). Health benefits deductions made through (give beginning) and ending dates of payroll period in which leave-without-pay began)"

I HEREBY CERTIFY that the person who executed the foregoing claim for compensation was injured while in the performance of his duty for the United States. An official report of this injury on Form C. A. 2 has been made, and all statements made in said report are true to the best of my knowledge and belief.

_____
[*Signature of official superior*]

Signed this _____ day of _____, 19____ _____
[*Title*]

at _____

Form C. A. 4A

SAMPLE

In correspondence please refer to File No.

APPLICATION FOR AUGMENTED COMPENSATION FOR DISABILITY

To be submitted when claimant has dependents.

U. S. DEPARTMENT OF LABOR
BUREAU OF EMPLOYEES' COMPENSATION
WASHINGTON 25, D. C.

NOTE.—*Read carefully instructions on reverse side* before executing this application. When executed give to your official superior to be forwarded to the above address.

I certify that on account of the injury sustained by me on August 14, 1962 (Date of injury) I am entitled to augmented compensation under section 6 of the Federal Employees' Compensation Act. The answers to the questions on this form shall be considered and read as part of my claim on Form C. A. 4.

Pursuant to paragraphs V and XI of the instructions, check below the person on account of whom you claim you are entitled to augmented compensation.

ITEMS.—(A) WIFE X (B) HUSBAND _____ (C) CHILD X (D) PARENT _____

Fill out below any item which you have checked. If you are divorced you cannot claim under item (A) or item (B).

ITEM (A) WIFE.—(1) Were you married by a ceremony? _____ (Yes or no) (2) Date and place of marriage June 20, 1952 at Las Vegas, Nevada (3) If married by a nonceremonial marriage give details _____

(4) Were you or your spouse previously married? no (Yes or no) (5) If so, state how such marriage or marriages was/were terminated _____

(6) Is your wife a member of the same household as you? yes (Yes or no) If answer to No. (6) is "No" answer the following questions: (7) Present address of your wife _____ (8) If not member of your household is your wife receiving regular contributions from you toward her support? _____ (Yes or no) (9) State the amount thereof per month or the equivalent in kind, $_____ (10) Have you been ordered by any court to contribute to the support of your wife? _____ (Yes or no) If so, attach copy of such order.

ITEM (B) HUSBAND.—If you are a wife and making claim for these additional payments because of support of a husband, first fill out questions 1, 2, 3, 4, 5, and 6 in item (A) above and also the following: (11) Name and address of husband _____ (12) Is your husband wholly dependent upon you for support by reason of a physical or mental disability? _____ (Yes or no) (13) Give details _____

(A medical certificate of your husband's condition may be required later. You may, however, submit a medical certificate of his condition with this form at this time and avoid possible delay. Such report should include the physician's reasons for belief that such disability prevents self-support.)

ITEM (C) CHILD.—(14) If you are the parent of an unmarried child or children under the age of 18 or if over the age of 18 and incapable of self-support by reason of physical or mental disability, state the name and birth date of any one of such children who is either a member of your household or whom you are supporting Mary L. Squeeks, 8/3/56

(15) Is the child a member of your household? yes (Yes or no) (16) If not, state what amount, if any, you contribute monthly toward the

support of such child. (If other than money, specify.) $

(17) Name and address of person to whom such contributions are made

NOTE.—If the child named is incapable of self-support, attach a physician's report describing the child's condition and the physician's reasons for belief that such disability prevents self-support.

ITEM (D) PARENT.—(18) The following parent or parents are wholly dependent upon, and are supported by me:

Name	*Address*	*Age*	*Legal Relationship* (Natural, step, or parent by adoption)

(19) If the parent (or parents) is not a member of your household, state what amount, if any, you contribute monthly toward the support of such parent (or parents) in money or otherwise, $

If any change occurs in the status of any person named in this application during the period for which I am entitled to augmented compensation I will notify the Bureau giving the date and nature of such change. I will promptly return any check or checks I might receive for the period after such change occurs. The penalties set forth below for making any false statement in this application have been read and are fully understood.

I certify that before signing this application I have read it and the instructions furnished below and that the statements in this form are true according to my best knowledge and belief, and that the disclosures in this form are in all respects full and complete.

/s/ Dan P. Squeeks
(Signature)

Mailing address

314 Florida Avenue

Alamogordo, New Mexico

Signed this 24th Day of August, 1962

at Alamogordo, New Mexico
(City or town and State where signed)

CAUTION.—A person who knowingly makes any false statement, misrepresentation, concealment of fact, etc., in respect to this claim is subject to criminal prosecution and may be punished by a fine of $10,000, or imprisonment for 5 years, or both, under the laws of the United States. All statements should therefore be very carefully reviewed for correctness.

A claimant who knowingly accepts the increased compensation provided for by section 6 (a) (1) of the Federal Employees' Compensation Act to which he is not entitled after the marriage of a child, is subject to prosecution and may be punished by a fine of $2,000 or by imprisonment for 1 year, or both.

STATEMENT OF OFFICIAL SUPERIOR.—Is the information furnished by claimant in agreement with that furnished by him on Form W 4? (Casual firefighter - No W-4 required)
(Yes or no)

Has the claimant, according to your best knowledge and belief, correctly stated the facts in this claim with reference to his dependents? yes
(Yes or no)

If answer is "No," attach separate written statement over your signature, giving any discrepancies in the applicant's statement.

Alamogordo, New Mexico
(City or town and State where signed)

August 24, 1962
(Date)

/s/ Wm. T. Green, Acting Forest Supervisor
(Signature of official superior)

Lincoln National Forest
(Title)

16—60583-2

SAMPLE

REPORT OF TERMINATION OF TOTAL ~~OR PARTIAL~~ DISABILITY

(Cross out one)

[To be forwarded to the U. S. DEPARTMENT OF LABOR, BUREAU OF EMPLOYEES' COMPENSATION, Washington 25, D. C., through official channels as soon as disability from injury terminates. This form to be submitted for each injury resulting in any disability, whether or not employee makes claim for compensation.]

1. Department Agriculture (War, Navy, etc.) 2. Bureau or office Lincoln National Forest (Engineer, Navigation, etc.)
3. Place of employment Olson Canyon Fire - Headquarters at Alamogordo, New Mexico (Arsenal, Navy Yard, etc.) (City or town.) (State.)
4. Full name of injured employee Dan P. Squeeks
5. Time of injury August 14 (Date.), 1962, Tuesday (Day of week.) 8:30 a.m. (Hour, a. m. or p. m.)
6. Time employee stopped work August 14 (Date.), 1962, Tuesday (Day of week.) 9:00 a.m. (Hour, a. m. or p. m.)
7. Time employee's pay stopped August 14 (Date.), 1962, Tuesday (Day of week.) 12 Noon m. (Hour, a. m. or p. m.)
8. First day employee was able to resume work 8/24 (Date.), 1962 Friday (Day of week.) 8:00 a.m. (Hour, a. m. or p. m.)
9. Did employee return to the same work and at same rate of pay after termination of disability? no
   If so, when? ..... If not, state character of work performed upon return to duty and rate paid employee for such work Employee was casual firefighter and the need for his services ceased on August 18, 1962 when the fire was extinguished.
10. Actual time disabled (including Sundays and holidays) ten days.
11. Number of days for which employee would have received pay had he not been disabled nine days.
12. If employee was receiving subsistence as part of his wages, was such subsistence furnished during entire period of disability? no If not, give dates on which subsistence was not furnished
    no subsistence furnished during entire period of disability
13. Has employee been paid for any portion of above absence on account of—
    (*a*) Annual leave? no (Give exact dates.)
    (*b*) Sick leave? no (Give exact dates.)
    (*c*) Any other reason no
14. Nature of injury Abrasions and burns on face, bruished right arm
15. Remarks Item 11 shows possible work days had fire services been needed during entire period of disability. Not eligible for Health Benefits.

CA-3 Report of Termination of Total or Partial Disability

[The following information is to be furnished *only* in case of death resulting from an injury sustained while in the performance of duty. If death results immediately, or if no Report of Injury has previously been submitted, such report, on Form C. A. 2, should be forwarded herewith.]

REPORT OF DEATH

16. Full name of deceased employee _____

17. Time of death _____ (*Date.*), 19 _____ (*Day of week.*) _____ (*Hour, a. m. or p. m.*) m.

18. Time employee's pay stopped _____ (*Date.*), 19 _____ (*Day of week.*) _____ (*Hour, a. m. or p. m.*) m.

19. Place of death _____ (*Name of hospital, establishment, etc.*) _____ (*City or town, and State.*)

20. Immediate cause of death _____

21. Widow of deceased employee _____ (*Give full name.*) _____ (*Address.*)

22. Children of deceased employee under 18 years of age, or those over 18 who are incapable of self-support:

Name.	*Age.*

23. Names, relationship, and addresses of all other persons known to be dependent, in any degree, upon decedent at time of death:

Name.	*Relationship.*	*Address.*

Signed this 24th day of August, 1962

/s/ Wm. T. Green
(*Official superior.*)

Acting Forest Supervisor
(*Title.*)

C. A. 3
Revised September 26, 1952

☆ U S GOVERNMENT PRINTING OFFICE 1957—O-410417

AD-278 (5-62)

U. S. DEPARTMENT OF AGRICULTURE

SUPERVISOR'S REPORT OF ACCIDENT

EXCEPTION TO SF-91A AND SF-92. APPROVED BY BUREAU OF THE BUDGET AUGUST, 1961

AGENCY: Your Agency

CASE NO. (COL. 1 - 4): Use if Required

SECTION I - GENERAL ACCIDENT DATA

1. NAME OF EMPLOYEE INVOLVED: John J. Doe

2. AGE: 31 | 3. SEX: M | 4. DRIVER'S LICENSE NO. STATE Cal177476 FED. WR123

5. LOCATION OF ACCIDENT (Shop, lab, street, etc.): Great Plain Exp. Station, Sacramento, Cal.

6. NAME AND ADDRESS OF	WITNESS	INJURED
John J. Doe		X
Blake Dennu	X	

7. NARRATIVE DESCRIPTION OF ACCIDENT (Tell when, where, why and how it happened. Identify the equipment and property involved and explain extent of damage or injury. Attach extra sheets if necessary to complete the narrative, to list additional witnesses and for diagrams.)

At 9:00a.m., April 5, 1963, John Doe, a laborer, was loading a Roto Tiller into the bed of Pick up truck No. 2. He used a 2" x 6" as a skid. The Tiller fell striking John on the left leg and foot. The tail light on the truck was broken. The gear box and blades of the Tiller were damaged.

John was treated bu a local Doctor. X-rays showed no broken bones. John returned to work the next work dau. (Monday, April 8)

Blake Dennu working nearbu did not see the accident. He looked up when he heard it.

"Corrective Action"

"Agree with Supervisor and have issued a Standard Procedure for loading heavu equipment."

SECTION II - CODED ACCIDENT DATA

		CODE
8. DIVISION		
(Your Division)	5 - 6	Code
9. UNIT OR STATION		
(Your Unit)	7 - 10	Code
10. OCCUPATION OF EMPLOYEE INVOLVED		
Laborer	11 - 12	01
11. FUNCTIONAL ACTIVITY (Optional use)		
(Use if Instructed)	13 - 14	Code
12. TYPE OF ACCIDENT BEING REPORTED		
Property Damage & Injury	15	3
13. DATE OF ACCIDENT		
April 5, 1963	16 - 19	0405
14. TIME OF ACCIDENT		
9:00 a.m.	20 - 21	09
15. AGENCY OF ACCIDENT		
Roto Tiller (Machine)	22 - 23	17
16. MECHANICAL OR PHYSICAL FACTOR INVOLVED		
Hazardous Procedure	24 - 25	04
17. ACT OF EMPLOYEE INVOLVED		
Unsafe Loading	26 - 27	09
18. EMPLOYEE'S PERSONAL FACTOR		
Lack of Know-how	28 - 29	03
19. EXTENT OF INJURY TO EMPLOYEE		
Temporary Partial (Med)	30	2
20. NATURE OF INJURY		
Bruises & abrasions	31 - 32	02
21. PART OF BODY INJURED		
Leg & foot	33 - 34	08
22. CAUSE OF INJURY		
Struck bu Roto Tiller	35 - 36	02
23. COST OF REPAIR TO USDA PROPERTY		
Roto Tiller $60.00	37 - 42	000060
24. COST OF REPAIR TO USDA VEHICLE		
Tail light assembly $15.00	43 - 46	0015
25. COST OF REPAIR TO GSA PROPERTY		
NA	47 - 50	---
26. COST OF REPAIR TO GSA VEHICLE		
NA	51 - 54	---
27. COST OF REPAIR TO PRIVATE PROPERTY USED ON OFFICIAL BUSINESS		
NA	55 - 58	---
28. COST OF REPAIR TO OTHER PRIVATE PROPERTY		
NA	59 - 62	---
29. COST OF MEDICAL SERVICES FOR INJURED EMPLOYEE		
X-ray treatment $15.00	63 - 66	0015
30. COST OF WAGES TO INJURED EMPLOYEE WHILE OFF DUTY		
NA	67 - 71	---
31. DAYS INJURED EMPLOYEE WAS OFF DUTY		
None	72 - 74	---
32. IF FIRE, HOW WAS IT CAUSED?		
NA	75 - 76	---

SECTION III - CORRECTIVE ACTION	RECOMMENDED	COMPLETED
33. ADDITIONAL EMPLOYEE TRAINING: Safe practices	X	X
34. CORRECTED PROCEDURE: Get help on heavu jobs	X	
35. IMPROVED HOUSEKEEPING		
36. REPORTING SUPERVISOR'S SIGNATURE (Explain corrective action in Item 7): John Brown	DATE: 4-8-63	

SECTION III - CORRECTIVE ACTION	RECOMMENDED	COMPLETED
37. ADDITIONAL SUPERVISORY TRAINING		
38. INSTALL SAFETY DEVICE OR PROVIDE PERS. PROTECTIVE EQUIPMENT		
39. OTHER: "Corrected Procedure"		5=9=63
40. REVIEWING OFFICIAL'S SIGNATURE (Explain corrective action in Item 7): Ira Blue		DATE 5=9=63

AD-278 Supervisor's Report of Accident (front of form)

Accident reports provide facts essential to safety planning. The objective is to discover the causes of accidents and take the action necessary to prevent similar incidents. To accomplish this objective, it is imperative that all property damage accidents be reported. It is impossible to contemplate the cause of fatal and serious injury accidents before they occur. However, through action to prevent the recurrence of property damage accidents, supervisors can minimize the chance of fatal or serious injuries.

Supervisors should orient their employees on the subject of accident reporting and require oral or written reports from employees on all property damage, first aid and medical treatment accidents, as well as those which result in deaths and lost-time injuries. Form AD-278 is to be completed in quadruplicate by supervisors. The original and two copies are to be distributed according to agency instructions and the fourth copy is to be retained locally.

Supervisors are to insert appropriate code numbers in the "code" column of the form. An agency may use and code the case number, if it wishes. The following codes apply to Section II of Form AD-278:

Item 8 Division

Each agency is to provide its own code.

Item 9 Unit or Station

Each agency may provide its own code.

Item 10 Occupation or Job Title	Code
Laborer	01
Skilled trades worker	02
Foreman or job supervisor	03
Aid or technician	04
Professional	05
Research professional	06
Office worker (clerk, secretary, etc.)	07
Office worker (administrative level)	08
Other (explain)	09

Item 11 Functional Activity — Code

Each agency using this item shall provide its own code.

Item 12 Type of Accident

Property damage only	1
Injury accident only	2
Property damage and injury	3

Item 13 Date

Allow two digits for month and two for date; e.g., Jonuory 5 is 0105, October 17 is 1017, etc.

Item 14 Time

Code the hour from 00 to 23; e.g., 00 for 12 midnight is 12:59 a.m., 11 for 11:00 to 11:59 a.m., 15 for 3:00 to 3:59 p.m., etc.

Item 15 Agency of Accident

Aircraft	01
Domestic animal	02
Insect	03
Snake or reptile	04
Wild animal	05
Boiler or pressure vessel	06
Chemical	07
Conveyor	08
Dust	09
Electrical apparatus	10
Elevator	11
Hand tool (manual)	12
Hand tool (electric)	13
Flammables or hot substance	14
Hoisting apparatus	15
Radioactive substance	16
Machine	17
Mechanical power transmission	18
Pump or prime mover	19
Motor vehicle	20
Working surface	21
Ladder	22
Other (explain)	23

Item 16 Mechanical or Physical Condition

Defective equipment	01
Defective material	02
Hazardous arrangement	03

Item 16 - Continued — Code

Hazardous procedure	04
Improper illumination	05
Improper ventilation	06
Improper guarding	07
Improper marking	08
Unsafe dress	09
Unsafe working surface	10
Other (explain)	11

Item 17 Employee's Act

Distraction - horseplay	01
Wearing unsafe attire	02
Failure to wear safety apparel	03
Making safety device inoperable	04
Operating or working at unsafe speeds	05
Operating without authority	06
Failure to secure or warn	07
Unsafe procedure or position	08
Unsafe loading, mixing or storing	09
Using unsafe equipment	10
Using improper equipment or device	11
Working with dangerous equipment or material	12
Failure to comply with rules or procedures	13
Other (explain)	14

Item 18 Employee's Personal Factor

Bodily defect	01
Improper attitude	02
Lack of knowledge or skill	03
Other (explain)	04

Item 19 Extent of Injury

First aid cases	1
Temporary partial (medical treatment)	2
Temporary total	3
Permanent partial	4
Permanent total	5
Fatal	6

Item 20 Nature of Injury

Amputation	01
Bruise, contusion or abrasion	02
Burn or scald	03
Concussion	04
Laceration	05
Dermatitis	06
Fracture	07
Hernia	08
Puncture	09
Strain or sprain	10

Item 20 - Continued — Code

Other (explain)	11

Item 21 Part of Body Injured

Head or Neck	01
Eye(s)	02
Hand(s)	03
Arm(s)	04
Body	05
Back	06
Internal	07
Leg(s)	08
Foot (feet)	09
Multiple injury	10

Item 22 Cause of Injury

Striking against	01
Struck by	02
Caught in, on, or between	03
Fall on same level	04
Fall to different level	05
Slip - no fall	06
Exposure to temperature extremes	07
Inhalation, absorption, ingestion	08
Contact with electric current	09
Other (explain)	10

Item 32 How Caused

Electricity	01
Spontaneous	02
Matches	03
Lightning	04
Smoking materials	05
Chemicals or explosives	06
Other (explain)	07

Items 23, 24, 25, 26, 27, 28, 29, 30 and 31 - code an estimate to the nearest whole number of the cost or days lost.

NOTE - If more than one USDA employee was injured in this accident, please complete items 1, 2 and 3 of Section 1, and items 19, 20, 21, 22, 29, 30 and 31 in Section II of another Form AD-278 for each additional injured employee, and attach these forms to the accident report.

District Offices

Bureau of Employees' Compensation

The following District Offices process claims arising out of injuries sustained by employees who are stationed in or working out of offices located in the States comprising the district.

(1) *San Francisco District Office.* This district comprises the States of California, Nevada, Utah, Arizona, Colorado, and New Mexico. The address is: Bureau of Employees' Compensation, U.S. Department of Labor, U.S. Appraisers Building, 305 Golden Gate Avenue, San Francisco, Calif., 94102.

(2) *Chicago District Office.* This district comprises the States of Illinois, Iowa, Kansas, Minnesota, Missouri, Nebraska, North Dakota, Oklahoma, South Dakota and Wisconsin. The address is: Bureau of Employees' Compensation, U.S. Department of Labor, 14 East Jackson Boulevard, Chicago, Ill., 60604.

(3) *Boston District Office.* This district comprises the States of Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island and Vermont. The address is: Bureau of Employees' Compensation, U.S. Department of Labor, 18 Oliver Street, Boston, Mass., 02110.

(4) *New York District Office.* This district comprises the States of Delaware, New Jersey, New York and Pennsylvania. The address is: Bureau of Employees' Compensation, U.S. Department of Labor, 321 West 44th Street, New York, N.Y., 10036.

(5) *Cleveland District Office.* This district comprises the States of Indiana, Kentucky, Michigan, Ohio, Tennessee and West Virginia. The address is: Bureau of Employees' Compensation, U.S. Department of Labor, 33 Public Square, Public Square Building, Cleveland, Ohio, 44113.

(6) *Jacksonville District Office.* This district comprises the States of Florida, Georgia and South Carolina. The address is: Bureau of Employees' Compensation, U.S. Department of Labor, Fidelity Federal Savings and Loan Association Building, 411 West Adams Street, Jacksonville, Fla., 32202.

(7) *New Orleans District Office.* This district comprises the States of Alabama, Arkansas, Louisiana, Mississippi, and Texas. The address is: Bureau of Employees' Compensation, U.S. Department of Labor, 114 North Rocheblave Street, New Orleans, La., 70119.

(8) *Seattle District Office.* This district comprises the States of Alaska, Idaho, Montana, Oregon, Washington and Wyoming. The address is: Bureau of Employees' Compensation, U.S. Department of Labor, Smith Tower Building, Room 2008, 506 Second Avenue, Seattle, Wash., 98104.

(9) *Honolulu District Office.* This district includes offices located in the Pacific area including all land and water areas outside the continents of North and South America which are south of the 45th degree north latitude and westward from the 110th degree west longitude to the 60th degree east longitude, except areas in the North Atlantic Ocean and contiguous waters. The address is: Bureau of Employees' Compensation, U.S. Department of Labor, 680 Ala Moana Boulevard, Room 408, Honolulu, Hawaii, 96813.

Compensation Act Basic Forms*

On the following pages is a list of the basic forms issued by the Bureau of Employees' Compensation for use in reporting injuries under the Federal Employees' Compensation Act. (Please note: Forms marked with an asterisk are furnished direct to claimants or to hospitals and physicians by BEC.)

This list has been prepared as a ready reference for administrative officers and supervisors in all agencies. Its purpose is to give brief instructions for the most important forms used in filing claims for compensation under the Federal Employees' Compensation Act.

This list does not mention all the forms used in adjudicating claims, nor is it intended to be a substitute for the Bureau's Regulations. Other forms, not referred to in this list, are used for special purposes, and will be provided by the Bureau when the need arises. For example the following:

NO.	TITLE
*CA–5A	Application for Balance of Scheduled Award Due When Death Is From Causes Other Than The Injury.
*BEC–77	Instructions for Submitting Travel Vouchers.
*CA–42	Affidavit Relating to Representatives of Deceased Beneficiaries.
*BEC–60	Certification of Mortician.
*CA–96	Affidavit of Earnings of Disabled Employee.
*SF–1034	Public Voucher for Purchases and Services Other Than Personal.
*BEC–205	Physician's Report on Eye Disabilities.

*Note: As BEC revises existing forms or issues new forms they are changing form designations from CA to BEC and in some instances they change the form number and title. Pen and ink changes should be made in this Guide when such changes are made.

Form No.	Form Title	Purpose
CA–1 (4/62)	Employee's Notice of Injury or Occupational Disease.	Notifies Official Superior of injury.
CA–2 (12/61)	Official Superior's Report of Injury.	Official Superior shall report to BEC (1) when injury is likely to result in any medical charge against the Compensation Fund or (2) in any disability for work beyond the day, shift, or turn of the occurrence or (3) injury appears likely to require prolonged treatment or (4) to result in future disability or (5) to result in any permanent disability, including the total or partial loss or loss of use of a member of the body or (6) to result in serious disfigurement of the face, head, or neck.
CA–3 (9/52)	Report of Termination of Total or Partial Disability; Report of Death.	Notifies BEC that disability from injury has terminated, or, notifies BEC when employee dies as a result of the injury.
CA–4 (12/61)	Claim for Compensation on Account of Injury.	To claim compensation when injury results in (1) loss of pay for more than 3 days or (2) permanent disability involving the total or partial loss, or loss of use of a member of the body (or hearing or vision) or serious disfigurement of the face, head, or neck; or (3) loss of wage-earning capacity.
CA–4A	Application for Augmented Compensation for Disability.	To claim compensation for augmented compensation based on dependents.
CA–5 (5/50)	Claim for Compensation on Account of Death.	To claim compensation when injury results in death.
CA–8 (9/52)	Claim for Continuance of Compensation on Account of Disability.	To claim compensation when loss of pay continues beyond the time covered by the original claim on Form CA–4.

References	Prepared by—	When submitted	Completed Form sent to—
Section 1.2 Federal Employees' Compensation Act Regulations.	Employee or someone on his behalf. Immediate Superior and witnesses signatures.	Within 48 hours.	Filed in official personnel folder if no report to BEC.
Sections 1.3 and 1.7 of the Regulations.	Official Superior, witnesses and physician.	Immediately after the injury.	Appropriate BEC Office accompanied by CA–1.
Sections 1.6 and 1.12 of the Regulations.	Official Superior.	Immediately after the employee returns to work, or immediately after death.	Appropriate BEC Office.
Section 1.4 of the Regulations.	Employee or someone on his behalf, attending physician and Official Superior.	After employee loses pay for 18 days, or when disability terminates if he lost pay for more than 3 days or when it is known employee is entitled to compensation for loss or loss of use of a member.	Appropriate BEC Office.
Section 1.5 of the Regulations.	Employee or someone on his behalf, and Official Superior.	With Form CA–4.	Appropriate BEC Office.
Section 1.13 of the Regulations.	Official Superior, attending physician and person claiming compensation.	Within 1 month, if possible, but not later than 1 year after death.	Appropriate BEC Office.
Section 1.8 of the Regulations.	Employee or someone on his behalf. Also attending physician and Official Superior.	Semimonthly.	Appropriate BEC Office.

Form No.	Form Title	Purpose
CA–12 (7/58)	Claim for Continuance of Compensation.	Provides information for BEC to determine if compensation may be continued.
CA–16	Request for Treatment of Injury under the United States Employees' Compensation Act.	Authorizes treatment of injured employees by a U.S. Medical Officer or Hospital or by a designated physician when there is no doubt as to injury in performance of duty.
CA–17	Request for Treatment of Injury under the United States Employees' Compensation Act when Cause of Injury is in Doubt.	Authorizes examination and emergency treatment only of injured employees by a U.S. Medical Officer or hospital or by a designated physician when the cause of injury is in doubt.
CA–20 (1/40)	Attending Physician's Report.	Provides BEC with medical report.
CA–32	Report on Hernia.	Provides BEC with medical report in hernia cases.
BEC–129 BEC–129a (1/63) formerly S–69	Public Voucher for Services and Supplies of Hospitals and Physicians.	Itemizes charges for medical, hospital, surgical, or other treatment or care of injured employees. Billhead stationery may be used in its place.
BEC–134 (1/63) formerly CA–101	Instructions for Claiming Charges for Medical and Hospital Services and for Appliances and Supplies Furnished under the Federal Employees' Compensation Act.	Instructs doctors, hospitals, and vendors of medical supplies and appliances how to submit bills.
Standard Form 1012 and 1012a	Travel Voucher.	Claim for reimbursement of necessary transportation expenses incurred in securing medical treatment, appliances or supplies for results of injury in performance of duties.

References	Prepared by—	When submitted	Completed Form sent to—
Section 1.14 of the Regulations.	Claimant or guardian.	Within 30 days after received from BEC.	Appropriate BEC Office.
Sections 2.3 and 2.4 of the Regulations.	Official Superior.	Within 48 hours after emergency treatment is authorized.	Original to medical facility, copy to appropriate BEC Office.
Sections 2.3 and 2.5 of the Regulations.	Official Superior.	Within 48 hours after emergency treatment is authorized.	Original to medical facility, copy to appropriate BEC Office.
Section 2.10 of the Regulations.	Examining physician.	Immediately.	Appropriate BEC Office.
Section 2.10 of the Regulations.	Employee and examining physician.	Immediately.	Appropriate BEC Office.
Section 2.11 of the Regulations and Instruction Sheet BEC–134	Physician, Hospital or organization requesting payment.	Immediately after treatment or at the end of 30 days, whichever occurs first, and each 30 days thereafter.	Original and a copy to appropriate BEC Office. This applies to voucher form or billhead stationery.
Section 2.12 of the Regulations.	Traveler.	Immediately after travel is completed, or periodically for repeated trips.	Both forms to appropriate BEC Office.

For sale by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 – Price 35 cents

U.S. GOVERNMENT PRINTING OFFICE: 1963—O—693-506

Local
MEDICAL—HOSPITAL—AMBULANCE—EMERGENCY
Facilities

Write In For Ready Reference • Keep Up To Date
Use BEC designated facilities when available

X

FACILITY	ADDRESS	PHONE	

Have Action Plan Ready For Any Emergency

	PHONE
AMBULANCE	
EMERGENCY ROOM	
FIRE	
POLICE	

What to do . . .

1. **Know Your Rights** under the compensation law. Keep this notice along with your other valuable papers. You, your family, and your family's future may be dependent upon a thorough knowledge of it.

2. **Report Every Occupational Injury** to your immediate official superior without delay. If others were present at the time of your accident, get their names as witnesses.

3. **Secure First Aid** treatment first. Infection is painful and costly to you. Even under compensation you lose from 25% to 33 1/3% of your paycheck.

4. **Consult Your Supervisor** for the proper forms needed to secure adequate medical treatment, and to file a notice of injury, Form CA–1.

5. **Claim Form CA–4** for compensation should be submitted promptly whenever any loss of pay is involved. Although technically you may have a year in which to present a claim, the payment you're interested in is dependent upon prompt completion of Form CA–4. No compensation is paid without it!

6. **A Safe Workman** draws full pay regularly. Avoid the accident that causes the injury, but if you **are** injured, abide by the rules that assure full protection to yourself and your family.

WHEN IN DOUBT about your rights under compensation law write to the U.S. Department of Labor Bureau of Employees' Compensation